STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008900	A. BUILDING: _____ B. WING _____	03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL- INDIANAPOLIS	8060 KNUE ROAD INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State complaint investigation. Complaint number: IN 00148604 Unsubstantiated; lack of sufficient evidence. Date of Survey: 3/12/2015 Facility #: 008900 Surveyor: Nancy Otten, RN, Public Health Nurse Surveyor Select Speciality Hospital-Indianapolis is in compliance with 410 IAC 15-1.5-5, Medical Staff, 410 IAC 15-1.5-6, Nursing Services and 410 IAC15.1-5-10, Utilization Review and Discharge Planning, Hospital Licensure Rules. QA: claughlin 03/24/15	S 000		